



BLUEPRINT FOR CHANGE
EARLY CHILDHOOD

GIVE. ADVOCATE. VOLUNTEER.
LIVE UNITED 

UNITED WAY OF GREATER ROCHESTER

United Way of Greater Rochester

Blueprint for Change: Early Childhood

Setting the Stage

Our mission is to magnify and focus the power of community resources to prevent and address our most pressing social needs. Among the key strategic priorities integral to accomplishing our mission is to advance the common good by making a measurable impact in our community. This blueprint represents a new approach for planning how we will invest resources. While it does not fundamentally change our work, it likely will change how we go about that work.

In preparing for this new process, our Community Investment Cabinet worked with staff to develop the following resource investment philosophy.

Our investment philosophy builds on the foundation of our mission, vision and values and is intended to guide our work in making resource investment decisions that will accomplish meaningful and lasting change in peoples' lives.

- Our first responsibility is to serve our community.
- Our focus is clear—we identify priorities and implement effective and efficient strategies to achieve measurable results.
- We work for long-term success and seek to address the root causes of social problems.
- We hold ourselves accountable for the prudent investment of community resources.
- We are willing to take calculated risks and move with urgency to address our community's most pressing needs.
- We value transparency and accessibility through honest and full disclosure to donors, agencies and the general community.
- We build constructive relationships based on mutual respect, candor and understanding.
- We value the perspectives, opinions and experiences of the broadest-possible cross section of people to inform our decisions.
- We set high standards for all we do, assess our performance and learn from our mistakes.

It's also important to note that our blueprint helps guide our resource investment decisions. Just what does that mean? There are three major kinds of resources that the United Way can invest in particular areas of focus:

- 1) Give The United Way makes a financial commitment to a particular program in support of a strategy focused on a community needs.
- 2) Advocate The United Way serves as a convener, advocate and champion for issues identified by our blueprint process. This may result in a public policy initiative or simply convening community leaders for dialogue.
- 3) Volunteer The United Way serves as a catalyst in identifying volunteer needs to advance a strategy. For example, if more adults are needed to read to elementary classrooms, we'll issue a "call to action" to the community.

Any combination of these resources may be invested with the intent of making long-term, sustainable change in our community.

We began our work by learning from the community what matters most to them. After conducting surveys engaging more than 1,200 people, and talking with more than 100 human-service professionals, we learned that people are most concerned about these eight issues:

- 1) violence and unsafe neighborhoods
- 2) family violence, child and elder abuse
- 3) poverty/low income
- 4) support for non-professional caregivers
- 5) adequate food, shelter and clothing
- 6) young children prepared for school
- 7) low graduation rates
- 8) safe, affordable housing

Starting at the Beginning

With such a compelling list of needs, where do we begin? To understand how best to tackle the issues and to gain insight into the most effective preventive approaches, we turned to a variety of sources. The answer was quite simple and resoundingly endorsed: start at the beginning. Begin by focusing on early childhood.

Marian Wright Edelman of the Children's Defense Fund notes, "Since education is a key determinant of future success, and because brain development is greatest in the first three years of life, early childhood investment pays big dividends later."

One might expect such a viewpoint from a children's advocacy organization. But that idea was readily endorsed and expounded upon by Economics Nobel Laureate James Heckman of the University of Chicago.

In his current research, Heckman draws on neuroscience to demonstrate that factors including earnings, employment, college attendance, teenage pregnancy and participation in crime strongly depend on cognitive and non-cognitive abilities. In other words, they depend on the person's formal skills and personality traits. Influencing these personality traits has as much impact as formal education on these later-life outcomes.

According to Heckman, "skills beget skills." So, the earlier a child receives a foundation for learning (whether social or intellectual skills), the easier it is for that child to learn. That in turn leads to self-reinforcing to learn more.

Put in terms of return on investment in human capital, Heckman shows that the earlier the intervention, the higher the return. One study shows a ten-fold return on every dollar invested in children from birth to age three.

Closer to home, Dr. John Klofas, professor of criminal justice at Rochester Institute of Technology observed:

“In communities like ours, the burdens of poverty are carried by those with the fewest possible resources: the children. We must work to fully understand their lives. In doing so our commitment is clear. When you are 2 or 5 or 13, a lifetime of possibilities is captured in the clinical language of early intervention. Longer horizons have no meaning. We must be committed to understanding the successful efforts made here and elsewhere, to adoption and experimentation, and to always moving forward through examination, analysis and evaluation.”

And finally, perhaps the most startling observation was shared by Monroe County District Attorney Michael Green:

“While I was prosecuting potential capital cases (first-degree murder before the death penalty statute was declared unconstitutional), we would do extensive background investigations. In every such case I prosecuted the investigation revealed evidence of significant child abuse.”

Given that backdrop, we will start our work at the beginning—in early childhood. This reflects our commitment to prevention and long-term sustainable change. This early childhood blueprint will impact resource decisions for 2009. Blueprints for school success, seniors and crisis services will be completed in 2009, impacting 2010 resource decisions. We are also committed to integrate people with disabilities into an appropriate blueprint.

The Blueprint Process

The blueprint process is simply an enhanced planning tool that allows us to be more...

Inclusive

Hundreds of people were engaged in developing this blueprint. And as we shared the process, it changed along the way, thanks to invaluable input of everyone from donors to field experts. The names of those who helped bring our blueprint to life are listed in the acknowledgements at the end of this report.

Transparent

The blueprint provides important documentation of our thinking, our approach and how we intend to accomplish our goals.

Proactive

We have devoted resources to identify the most advanced approaches to community problem-solving so that our community invests its limited resources in strategies that will best address its problems.

We researched a continuum of program models, from emerging to evidence-based. Evidenced-based programs, as defined by The Children’s Agenda, are those “that have been evaluated using randomized control trials, have been replicated in other communities, and that have strong, positive, long-term outcomes.” Where available and affordable, evidence-based programs are preferred.

When evidence-based programs are not identified, we look to emerging practices. These are practices that show promise and may achieve evidenced-based status. In short, we plan on investing in programs that have been proven to work wherever we can. Where we can’t, we’ll devote the resources needed to evaluate emerging practices.

Evaluative

Historically, the United Way has tracked program outcomes. The blueprint process truly raises the bar to look at broader impact. Are our strategies working? What progress are we making toward our long-term goal? The blueprint will help us answer such questions.

The blueprint also articulates a formal assessment and evaluation plan that will ensure transparency to our provider partners and others.

The Center on the Developing Child at Harvard University underscores the importance of evaluation:

“No single program approach or mode of service delivery has been shown to be a magic bullet. The key is to select strategies that have documented effectiveness, assure that they are implemented well, and recognize the critical importance of a strong commitment to continuous program improvement.”

Collaborative

We can't address this work alone, nor can we do it by ourselves. We need strong funding, advocacy and volunteer partnerships. The blueprint process has already proven to be an invaluable tool in sharing our intentions and investments with those partners to help them make decisions and create increased synergy of community resources.

Culturally Competent

Cultural competency and sensitivity was a recurring theme voiced by many of those we talked with throughout the blueprint process. We know that in order to make a positive impact, services must be designed to respect and honor the beliefs, attitudes and behaviors of the people being served as well as those providing the services. Ensuring that this happens will be a continuing focus for the United Way as the process moves forward.

What We Believe about Early Childhood

“What we believe” represents a compilation of all that we know, assume and believe about early childhood.

- All children with positive support systems can reach their full potential.
- From gestation to age five is a critical time for the future cognitive, linguistic, social, emotional and motor development of children.
- Early prevention and intervention is effective and efficient in providing a strong foundation for future learning, behavior and health.
- Health, economic and racial demographics have a negative impact on the “life cycle” of children and families.
- Positive prenatal and postnatal experiences for both parent and child have a profound impact on future success.
- Children born at a healthy birth weight are best positioned for positive physical and emotional health.

- Child abuse and neglect is strongly related to juvenile delinquency, adult criminality and violent criminal behavior.
- Stressful and traumatic prenatal and postnatal experiences have a negative impact on early childhood development and lead to an increased risk of low academic performance and violence.
- Exposure to violence in infancy and early childhood has far-reaching developmental, behavioral and emotional consequences.
- Young children are highly emotionally vulnerable to the adverse influences of parental mental-health problems.
- Secure, nurturing and stable early relationships with caring adults are essential to healthy human development.

What We Know about Early Childhood

- More than one third of Rochester City School District (RCSD) kindergarteners are entering school with one or more problems that put them at-risk for poor school performance.¹
- 8.5% of babies born in Monroe County had a birth weight under 5.5 lbs. Within the city of Rochester, 10.7% of babies were born at low birth weight. Both are considerably worse than the national goal of fewer than 5% of births being low birth weight.²
- Children raised by stable caregivers are more likely to reach developmental milestones than those who aren't.³
- Depressed mothers are more likely to use negative parenting practices. Their children are more likely to exhibit cognitive and behavioral problems.⁴
- Poor inner-city women suffer from depression related to pregnancy and postpartum at double the rate of middle-class women.⁵
- Close to three-quarters of abused and/or neglected children do not form enduring bonds with a primary caregiver.⁶
- Child neglect is associated with cognitive, language and academic delays; anxiety; depression and behavioral problems. Physical abuse is linked to cognitive delays, post-traumatic stress disorder and behavioral problems. Children who are reported as abused and/or neglected are more likely to be arrested for violent crimes as juveniles and adults.⁷
- Child abuse and neglect reports in Monroe County are increasing. In 2007, 6,948 reports were made.⁸
- Parents and caretakers report that 16% of RCSD kindergarteners have witnessed violence in their neighborhoods. Eleven percent have witnessed violence in their homes.⁹
- Exposure to domestic and/or community violence can have negative effects on children's development, and has been linked to mental, behavioral and academic problems.¹⁰

- Parents and caretakers of children who attend early childhood programs supported by Rochester Early Childhood Assessment Partnership (RECAP) report that 18% of the children have a parent who has been incarcerated.¹¹
- Attendance in pre-kindergarten programs results later in lower drug use, higher graduation rates, fewer families receiving welfare, and lower crime.¹²
- At-risk children without quality pre-kindergarten are 70% more likely to commit violent crimes.¹³
- One study found that three- and four-year-olds who didn't attend preschool were five times more likely to have become chronic lawbreakers by age 27 than those who attended quality preschool.¹⁴
- A 2006–2007 assessment of the 162 pre-k classrooms served through RECAP show that they continue to be ranked among the highest in quality in both the United States and Europe.¹⁵
- Forty percent of Rochester children under age 5 live in poverty. Eighteen percent of Monroe County children under age 5 live in poverty. That's 7% of Caucasian children under age 5, compared with 45% of African American children and 43% of Latino children in the same age range.¹⁶
- During 2006, 795 babies were born to girls 15–19 in Monroe County, enough to fill about 36 kindergarten classrooms when they enter school. Annually, about 1 out of 5 births in Rochester is to a teenage girl.¹⁷
- Blood lead levels as low as 10 micrg/dL negatively affect children's cognitive functioning and behavior.¹⁸
- In 2007, 426 Monroe County children under age six were newly identified with dangerous blood lead levels—2.9% of the 14,917 screened.¹⁹
- The Child Welfare Information Gateway (2006) has identified some long term consequences of abuse and neglect.
 - Physical: Severe physical abuse or neglect can result in chronic health problems, broken bones, brain trauma or even death.
 - Psychological: Emotional effects can include fear, inability to trust, depression, anxiety, and difficulty in forming relationships.
 - Behavioral: Studies have found that abused and neglected children are at increased risk of such problems as delinquency, teen pregnancy, low academic achievement, substance abuse, arrest as a juvenile, and involvement in adult or violent crime.
 - Societal: Direct costs, such as law enforcement, child welfare systems and healthcare, and indirect costs, like juvenile and adult criminal activity, were recently estimated at more than \$94 billion per year for the United States and more than \$2.4 billion per year for New York State (Prevent Child Abuse America, 2001).

Goal and Objectives for Early Childhood

Goal: Every child in our community has the best-possible start in life.

To achieve the best-possible start and for children to have a foundation for sustained success, their basic needs must be met and they must:

- have secure attachments and nurturing, supportive families
- be free from physical, psychological and emotional abuse
- have parents who are emotionally equipped to embrace their role as their child's first teacher; have the capacity, skills and support systems for effective parenting; and participate in their child's early education
- have access to quality early childcare and education
- be cognitively, physically, emotionally, mentally and socially prepared for kindergarten

With that as our backdrop, we established the following outcomes and indicators.

Improved Parenting

- a. Increased parent knowledge of child development and parenting skills
- b. Increased positive parenting practices with respect to cultural differences
- c. Increased parental social support
- d. Reduced percentage of parents and children with substantiated child abuse reports
- e. Increased percentage of children exhibiting age-appropriate or developmentally appropriate social and emotional development

Increased School Readiness

- a. Increased percentage of children exhibiting age-appropriate or developmentally appropriate physical, emotional, social and cognitive development
- b. For those children in out-of-home care, increased use of high-quality childcare and early childhood education
- c. Increased number of children with special needs receiving screening and referral to appropriate care settings

Improved Child and Maternal Health

- a. Increased percentage of children exhibiting age-appropriate or developmentally appropriate physical, emotional, social and cognitive development
- b. Increased number of women and children screened and referred for appropriate services
- c. Increased use of needed services by women and children, including prenatal health care, primary health care, dental care, mental-health treatment and substance-abuse treatment
- d. Reduced prominent health and developmental risk factors for women and children, including blood lead levels, obesity, asthma, tobacco use, depression and other mental-health conditions

More Effective Service Delivery

- a. Increased coordination among agencies serving young children and their families
- b. Increased parent satisfaction with accessibility, cultural competence and responsiveness of the service system

Strategies for the United Way’s Resource Investments

The United Way has developed four strategies to achieve our goal and objectives. For each of these strategies, our investments may take the form of financial support, advocacy on issues, volunteer mobilization, or a combination of all three. Additionally, for those strategy areas in which the United Way will make a financial investment, we have identified from our research specific evidence-based programs and interventions that will address our goal and objectives. Detailed information on the research elements of those programs and interventions are available on the United Way of Greater Rochester’s website under the “For Service Providers” section.

We recognized that in the areas where we invest financially, we must consider funding some emerging practices in order to achieve our goal and objectives. We also recognize that each strategy area will require some level of advocacy and mobilization of volunteers.

Strategy 1: Parent Education

All across America, parents face challenges of raising children. Even in the most equipped families it can be a stressful job. Families at risk face myriad challenges—poverty, lack of education and isolation, for example—that can diminish their ability to support their children effectively. Parenting programs help strengthen parents’ education and increase their support systems and resources, which helps them to understand their child’s developmental needs and leads to appropriate nurturing and guidance.

The programs and interventions listed below take into account different types of parenting issues:

- Parents who simply want to increase their knowledge and effectiveness
- Parents who are dealing with specific issues, such as children with disabilities
- Specific groups of parents, such as single parents, those with low incomes, and those whose children are at critical periods in their development
- Parents who are dealing with specific discipline and behavior issues

The United Way will continue to make a financial investment in parent education. We have identified the following evidence-based programs.

The Incredible Years are research-based, proven, effective programs for reducing children’s aggression and behavior problems and increasing their social competence at home and at school. The programs—BASIC, ADVANCE and Dinosaur—focus primarily on parents with children aged 2–10 who are exhibiting conduct problems or are at risk for developing such problems.

The BASIC program educates parents of children aged 2–8 about social learning and child development. It focuses on strengthening parenting competencies, including positive discipline techniques. The program uses videotaped vignettes as an integral learning tool and is offered in 12–14 two-hour group sessions. BASIC can be followed by the ADVANCE program, which targets parents of children aged 4–10. ADVANCE’s 8–10 two-hour group sessions emphasize parents’ interpersonal skills, including effective communication, anger management and problem-solving.

Dinosaur programs focus on children and include classroom and treatment curricula. The Dinosaur classroom curriculum can be offered over several years from preschool to second grade, and emphasizes improving peer relationships and reducing aggression. The program’s treatment curriculum focuses on children aged 4–8 with conduct problems, and is offered in small groups in weekly two-hour session for 20–22 weeks. The treatment version focuses on anger management, empathy, and interpersonal problem-solving.

The purpose of the Incredible Years series is to prevent delinquency, drug abuse and violence. The short-term goals of the series are to:

- Reduce conduct problems in children
 - Decrease negative behaviors and noncompliance with parents at home
 - Decrease peer aggression and disruptive behaviors in the classroom
- Promote social, emotional and academic competence in children
 - Increase social skills
 - Increase understanding of feelings
 - Increase conflict-management skills and decrease negative attributions
 - Increase academic engagement, school readiness and cooperation with teachers

The monetary return on investment for Incredible Years cannot be calculated. In its report, “Benefits and Costs of Prevention and Early Intervention Programs for Youth,” the Washington State Institute for Public Policy (WSIPP) specifically mentions Incredible Years as a program for which it is unable to calculate a cost benefit, as its outcomes are not easily monetized.

Parents as Teachers uses the research-based Born to Learn™ curriculum for home visiting, which has demonstrated results in promoting optimal child development and positive parent-child relationships, including:

- Increased parent knowledge of early childhood development and improved parenting practices
- Early detection of developmental delays and health issues
- Prevention of child abuse and neglect
- Increased children’s school readiness and school success

The program is designed for pregnant families and those with young children up to five years old. Parent educators conduct monthly home visits (or more frequently if the family has higher needs) that include education on child development and parenting practices. They also engage in parent-child activities such as book reading. Children are screened at least once a year to assess their developmental progress as well as their vision, hearing, and overall health. Parent educators host monthly group meetings to share similar information as in home visits and give parents a chance to meet and support each other. Parent educators also connect families with appropriate community resources, including early intervention for developmental delays.

There is a return on investment related to Parents as Teachers. WSIPP estimates the costs per child of the total program at \$3,500 and the benefits at \$4,300. That amounts to a return of \$1.23 per dollar invested.

Nurse-Family Partnership® is an evidence-based, nurse home-visiting program that improves the health, well-being and self-sufficiency of low-income first-time parents and their children. The nurse home-visitors are highly trained registered nurses who follow a specific curriculum during client visits. The program starts with first-time mothers early in their pregnancy and continues through their child’s second birthday. Nurses and their clients make a significant 2½ year commitment to working together, and engage in 64 home visits lasting 60–90 minutes each. Visits are conducted weekly, biweekly or monthly depending upon the point in the pregnancy and the age of the child. This intensive level of support has achieved the following outcomes for mothers and their children.

- 48% reduction in child abuse and neglect
- 56% reduction in emergency-room visits due to accidents and poisonings
- 59% reduction in arrests at child age 15
- 67% reduction in behavioral and intellectual problems at child age six
- 72% fewer convictions of mothers at child age 15

There is a significant return on investment related to Nurse-Family Partnership. Rand's report, "Early Childhood Interventions: Proven Results, Future Promise," estimates the cost per child at \$7,271 and the benefits at \$41,419, with a return of \$5.70 per dollar spent.

Strategy 2: Kindergarten Readiness

The research is clear: from birth to age five is a critical time for brain development and growth. Given this, early quality childcare and education experiences along with the early involvement of parents in their children's education has a positive impact on kindergarten readiness. According to the NYS Early Childhood Data Report (2008), early learning includes cognitive development and skills as well as social-emotional development, emphasizing the essential roles and relationships with parents and other caregivers. It also includes physical and motor development, approaches to learning, and language, communications and literacy. Early experiences set a critical foundation for future learning.

In the area of Kindergarten Readiness, the United Way will continue to work with community stakeholders to advocate for quality services and access to high-quality childcare and education for low-income families. We will actively seek opportunities to mobilize volunteers for these efforts and other projects that arise. Where there is significant government investment in childcare subsidies, no investment of United Way dollars is expected.

Strategy 3: Early Detection, Screening and Connection to Services for Maternal-Child Health

Early screening and detection is critical for the success of both child and parent. According to the NYS Early Childhood Data Report (2008), critical development occurs very early in pregnancy and the earlier prenatal care begins the greater benefit it may provide. Adequate prenatal care allows for early detection, treatment and management of medical and obstetric conditions. The prevalence of children with special healthcare needs increases with age if they are not diagnosed or are misdiagnosed in their early years. Early recognition, diagnosis and proper treatment of special needs has the potential to greatly increase a child's quality of life.

The report further states that depression among young mothers has been shown to influence the mental health of their young children and that infants of mothers who are clinically depressed often withdraw, which can affect their language, physical and cognitive development.

In the area of Early Detection, Screening and Connection to Services, the United Way will make financial investments in the following evidence-based interventions.

Primary Mental Health Project is a school-based program designed for early detection and prevention of school-adjustment difficulties in children aged 4–9 in preschool through the third grade. The program screens children to identify those with problems such as mild aggression, withdrawal, and early difficulties that interfere with learning. For 10–14 weeks, eligible children meet weekly in one-on-one sessions with trained paraprofessionals. These 30-40-minute sessions include expressive play. Results of program participation include improvements in learning problems, aggressive behaviors and social skills among children with mild to moderate problems that could interfere with learning.

Child-Parent Psychotherapy is an intervention for children aged five and younger, including infants, who have 1) witnessed or been victims of trauma, including domestic violence and child abuse and neglect; 2) displayed related symptoms, including post-traumatic stress disorder, anxiety, withdrawal, poor attachment to the parent(s), and defiant behaviors; and/or 3) a mother with a major depressive disorder.

It involves weekly sessions for up to twelve months with the parents and the traumatized child. The goals of treatment include improving the parent-child relationship and restoring the child's mental health and normal developmental progression, which have been disrupted by exposure to trauma. Treatment results in improvements in maternal and child mental-health symptoms and mother-child attachment and interactions. The intervention works well for families exposed to domestic violence, child maltreatment, and maternal depression.

Interpersonal Psychotherapy is a structured, manual-based intervention that several research studies have shown to be effective in decreasing depression for adults and adolescents. It is generally offered in 12–16 weekly hour-long sessions, individually or in groups, and addresses interpersonal issues in depression, with a focus on improving the individual's problem-solving skills. Interpersonal psychotherapy is appropriate for adults and adolescents exhibiting depression due to bereavement; poor, dysfunctional, or insufficient interpersonal relationships; and stressful changes in life circumstances. The program results in improvements in depression symptoms and greater rates of remission.

Strategy 4: Systems Improvement

Improving the quality and accessibility of services for young children and their families is as critical as implementing effective programs. This is especially true in the current environment of increasingly complex needs and decreasing resources to address them. The United Way is committed to planning, implementing and sustaining high-quality systems that connect and improve local services. We envision a three-pronged approach to achieve this.

Learning Circles involve staff from United Way-funded early childhood programs. They will meet regularly to increase coordination among their agencies and share information about emerging programs to reduce duplication of effort and to increase overall provider knowledge for the benefit of clients.

Knowledge Management is a practice of harnessing intellectual capital through a practice of identifying, documenting and sharing information. During 2009, the United Way will launch an internal knowledge-management system designed to systematically capture information gained from meetings with experts, presentations, literature reviews and provider reports. This will serve as the foundation for a larger knowledge-management system in which funded agencies will participate. Participation includes the ability to add to the system's resources as well as retrieve information and post comments. This approach is intended to increase overall institutional memory and learning among the community of funded service providers. In the long term, we envision that the information harnessed through knowledge management will be made available to any interested party in our community.

The United Way's Synergy Fund provides technical assistance to agencies interested in exploring a different relationship in order to increase their capacity to pursue their mission. The United Way has entered into a partnership with the Council of Community Services of New York State (CCSNYS), an Albany-based organization with extensive experience in organizational re-engineering, to provide technical assistance to local agencies interested in exploring this opportunity. The process begins with an assessment of goals of the respective agencies, missions review, and assessing organizational cultural compatibility. Also provided are facilitation and preliminary due diligence necessary for the boards of both agencies to decide whether to enter into a good-faith agreement to negotiate a different kind of relationship, as are the accounting and legal services required to bring about an envisioned re-engineering that will achieve affiliation, consolidation or merger.

Supporting Strategies for Our Work

Supporting Strategy 1: Advocacy

The United Way engages in advocacy because we know that real and sustained change in community conditions requires more than money. Our advocacy efforts include public policy work as well as identifying opportunities to convene stakeholders to address local systemic issues.

These efforts, at the local, state and national levels, are often conducted in partnership with United Ways across the state and the country, magnifying our influence to further the goals of our early childhood strategies. We'll continue efforts to develop an advocacy agenda in support of early childhood strategies to include:

Advocacy on behalf of quality home-visitation programs

At the federal level, we expect the Education Begins at Home Act to be reintroduced in 2009. The act is intended to give many more children a quality early childhood experience with the help of home-visitation services. Funding will help states expand quality home-visitation programs in communities, and will target some specific groups of children and families for assistance. Specifically, the act will:

- Provide \$400 million over three years to states for expanded access to parent education and family support services through quality early childhood home-visitation programs;
- Provide \$50 million over three years to fund innovative ideas and partnerships at the local level to expand quality home-visitation services to families with English-language learners;
- Provide \$50 million over three years to provide home-visiting services to families of members of the United States Armed Forces living on military bases; and
- Strengthen the early childhood home-visitation components of Early Head Start.

Advocacy on behalf of access to quality childcare for low-income working families

A priority of the 2006–2009 public policy agenda was to increase access to quality childcare for low-income working families. Several elements of the strategy were achieved, including joining other funders to commission a childcare study that looked at decreased demand for childcare subsidies in relation to community need and increase in childcare subsidies up to the state market rate. We also saw unprecedented cooperation between the county and childcare advocates as they worked together to advocate with the state for increased funding in childcare block grants to support a greater portion of the documented need. Unfortunately, limited state resources resulted in a decrease of almost \$1.8 million in state funding for childcare in Monroe County. Consequently, the income eligibility for subsidies was decreased from 165% to 125% of the poverty level. Effective October 1, 2008, families between 125% and 165% previously receiving childcare support lost their subsidies.

There are still many opportunities to define a community position on the importance of quality early childhood experiences for all children, and support for families up to 200% of the poverty level to access these services for their children.

Advocacy for continued funding of 2-1-1 centers to ensure increased access to information and referral

For the people in our community needing help every day—from locating financial assistance during a family crisis, to finding adequate care for an aging parent, to searching for the highest-quality child care—2-1-1 is an easy-to-remember number to connect quickly with essential community resources. 2-1-1 also serves as a partner in disaster response and recovery, which is a key resource for people needing temporary shelter.

At the federal level, the United Way of Greater Rochester, in partnership with the United Way of America and United Ways across the country, is working to secure passage of the Calling for 2-1-1 Act. This act, originally sponsored by Sen. Hillary Clinton, would authorize \$700 million over six years to be distributed to states for use in fully implementing 2-1-1 nationwide. This legislation was referred to committee in both the House and Senate early in 2007, where it remains. Continued advocacy efforts at the federal level are required.

Advocacy efforts are required at the state level as well. Despite lack of federal movement, New York's 2-1-1 implementation efforts have continued with the help of state funding. However, that funding is at risk. During 2006–2007, state funding to help bring 2-1-1 to all New York residents totaled \$6.9 million. This was reduced slightly to \$6.3 million in 2007–2008. For the current year, funding was limited to \$500,000, and this amount has already been subjected to a 6% reduction due to budget cuts being made late in the budget year. The future of this important resource is at risk and continued advocacy at the state level for state funding is necessary.

Advocacy for lead-poisoning prevention

This year, more than 400 children in Monroe County will suffer permanent brain damage from lead poisoning. As a member of the Coalition to Prevent Lead Poisoning, the United Way is working toward the goal of ending childhood lead poisoning by 2010. Not only does the brain damage caused by lead poisoning result in learning disabilities, behavioral challenges and lifelong health problems, during 2008 researchers at the University of Cincinnati found that the higher the concentration of lead in children's blood, the more likely they were to be arrested during adulthood, especially for violent offenses.

While significant progress in reducing the number of children affected by lead poisoning is made each year, even one poisoned child is too many and we are still far from our goal. State legislation aimed at ending childhood lead poisoning has been sponsored by Assemblyman David Gantt for years. This year, bipartisan cooperation between Assemblyman Gantt and Senator Joe Robach resulted in passage of the Childhood Lead Poisoning Primary Prevention and Safe Housing Act. It was, however, vetoed by the governor, who cited funding limitations and other advances in lead-prevention efforts at the state level. The bill would have:

- Focused prevention efforts on 30 lead “hot spots,” including zip codes in Rochester;
- Resulted in a statewide childhood lead-poisoning prevention plan and related plans for the affected communities;
- Reduced the “trigger level” for intervention from 20 micrograms per deciliter to the Centers for Disease Control and Prevention's recommended level of 10; and
- Authorized a corporate tax credit for lead-hazard reduction activities.

Continued efforts to raise awareness of the dangers of lead poisoning, promote lead-safe housing and work with the state on expanding efforts to stop childhood lead poisoning are critical.

Advocacy on behalf of smooth transitions from early childhood education to school

In “Ladders of Learning: Fighting Fade-Out by Advancing PK-3 Alignment,” Kristie Kaure of Columbia University remarked, “*It is important to consider the quality of elementary schools into which children enter.*”

If children move from a high-quality PK program into a low-quality school, it is not surprising that fade-out occurs.”

The Children’s Agenda states, “*a community-wide focus on improving the quality of early elementary schools is vital to ensuring that the initial gains made by disadvantaged preschool children will not fade out (and that) early interventions adjust the trajectory of skill development before children fall too far behind their peers.*”

Conversations about school and community partnerships to ensure that we are all focusing on what works for students and parents.

Advocacy on behalf of increased access to health insurance for children

There are approximately 13,500 children living in Monroe County without health insurance. According to Families USA, “without coverage, children are less likely to have a regular source of health care, receive the preventive care they need, and get their other health care needs met”. United Way will support efforts to improve outreach and educate the public on subsidized health insurance and increased enrollment in Child Health Plus and Medicaid.

Supporting Strategy 2: Volunteerism

The gift of time is perhaps one of the most powerful ways to “give.” As part of our blueprint process, we will continue to work with providers to identify key volunteer opportunities that will help them advance their work. As we identify opportunities, the United Way is committed to actively working to spotlight them and recruit volunteers from the community. Some key volunteer opportunities identified in a forum of providers include:

- Classroom volunteers in preschools and childcare centers like those at CP Rochester
- Child care while parents attend Incredible Years parenting education at the Catholic Family Center
- Volunteer tax preparers for CASH program at Empire Justice
- Volunteers to knit hats and mittens for Early Childhood Education Quality Council childcare centers

We are committed to continue to identify opportunities and communicate them to the community. We will track and evaluate our ability to mobilize volunteers in support of our work in early childhood.

Assessing the Strategies

We are committed to an outcomes evaluation that will assess the effectiveness of individual funded programs, overall strategies and the blueprint. Evaluations will be designed to identify challenges and clarify accomplishments. All evaluations will focus on program outcomes. They will also include measures of process and implementation to maximize understanding of relationships between service delivery and results.

We expect that most of the programs to be supported will be evidence-based programs that have already demonstrated effectiveness through rigorous evaluation. For these programs, we will rely on the data-collection tools already in use by, or available to, service providers as the primary means of obtaining data for evaluations. Each program, however, will have an individualized evaluation design and plans for data collection and analysis.

For programs that do not rely on evidence-based models, we will require the design of program-specific data-collection tools (possibly modified from the ASQ or ASQ-SE). Each of these programs will also have a specific evaluation design, data collection, and analysis plan. We will work with all providers and evaluators to ensure that data-collection tools are valid and appropriate.

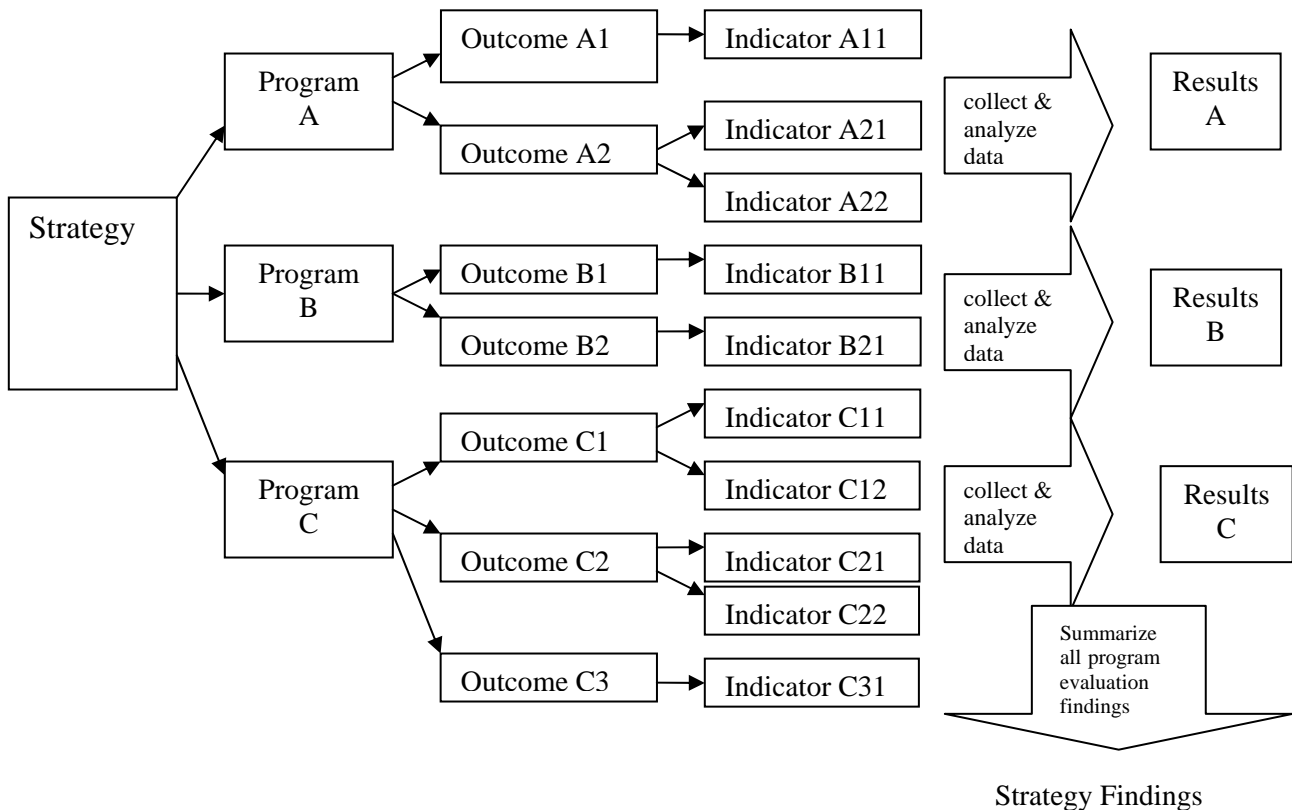
Results of all program evaluations will be reported on schedules developed for the individual evaluation design. Funded programs will be required to regularly submit specific outcome data (as specified in their evaluation design) and/or participate in evaluations commissioned by the United Way.

We anticipate that we will commission an outside evaluator to assist in this multi-dimensional evaluation process. In addition to program evaluations, there will be strategy evaluations informed by the results of multiple program evaluations. We will also seek to understand the outcomes of the overall blueprint. To accomplish this we intend to evaluate the results of all strategy evaluations.

In many program evaluations, we will require evaluators to collect specific feedback from key stakeholders. Additionally, we may commission strategy-level collections of feedback by surveying stakeholders about the effectiveness of the strategy. We also may require that other administrative data, such as county child-welfare statistics, be collected and analyzed to further understand strategy outcomes.

We plan to share with the broader community key lessons from the results of our strategy and blueprint evaluations so that our results can influence and inform other efforts.

The following diagram illustrates strategy-level evaluation that looks to the programs funded at the outcome and indicator level, and seeks to find commonalities across the indicators where possible to aggregate results. The strategy evaluation may also select from funded programs and require sharing client-level data with an outside evaluator who will conduct an analysis and provide feedback on the impact of the overall strategy.



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Early Childhood Advisory Council

Our Early Childhood Advisory Council works with staff to identify, prioritize, focus and support initiatives and programs. They provide insight that informs strategic investment of resources and advocacy as well as expertise that guides effective investment decisions.

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Melissa Wendland, Provider Relations Coordinator, Rochester Individual Practice Association

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The role of the Peer Review Panel was to offer feedback and counsel on the final draft of the blueprint.

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Our thanks to these professionals and groups for their invaluable participation and input in the development of this blueprint.

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 Child Care Council
 Family Resource Centers of Crestwood
 Community Place of Greater Rochester
 Rochester Hearing and Speech Center
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 Early Childhood Education Quality Council
 Halcyon Hill Foundation
 Mental Health Association of Rochester

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EARLY CHILDHOOD GLOSSARY

Advisory Council: A group of United Way volunteers who work within a focus area with United Way staff to identify, prioritize, focus and support initiatives and programs. They provide insight that informs strategic investment of resources and advocacy as well as expertise that guides effective investment decisions.

Advocacy: The act increasing public awareness of a particular issue or set of issues, actively supporting a cause and deliberately influencing those who make policy decisions.

Best Practices: Processes, practices or systems widely recognized as improving the performance and efficiency of organizations in a target area such as early childhood.

Blueprint for Change: A planning tool that will inform the United Way's investment strategies as well as its advocacy and volunteer efforts. The Blueprint for Change is based on the Theory of Change. (See Theory of Change.)

Child Maltreatment: Per public law 93-247, the physical and mental injury, sexual abuse or neglected treatment of a child under age 18 by a person who is responsible for the child's welfare under circumstances which indicate the child's health and welfare is harmed and threatened.

Cultural Appropriateness: Relates to sensitivity to the differences among ethnic, racial and/or linguistic groups, and awareness of how people's cultural background, beliefs, traditions, socio-economic status, history and other factors affect their needs and their response to services.

Cultural Competence: The knowledge and sensitivity necessary to tailor interventions and services to reflect the norms and culture of a target population and avoid styles of behavior and communication that are inappropriate, marginalizing or offensive to that population. Because of the changing nature of people and cultures, cultural competency is seen as a continual and evolving process of adaptation and refinement.

Delinquency: Juvenile delinquency is the legal term for behavior of children and adolescents that in adults would be judged criminal under law. Theft is the most common offense by children; more serious property crimes and rape are most frequently committed in later youth. Clinical studies have uncovered emotional maladjustments, usually arising from disorganized family situations, in many delinquents.

Developmental Milestones: Physical or behavioral signs of development or maturation of infants and children. Rolling over, crawling, walking and talking are considered developmental milestones and provide important information regarding a child's development. The milestones are different for each age range.

Early Childhood: Youth prenatal to age five.

Emerging Practices: Practices that appear likely to ultimately be effective, but which have yet to be evaluated at the same level of rigor as evidence-based practices.

Evidence-Based Practices and Programs: Approaches supported by scientific evidence showing that a practice is effective in increasing positive outcomes, such as increasing school readiness, and/or reducing negative ones like child abuse. Although there is no universal standard to define the quality or quantity of research necessary to conclude a practice is "evidence-based," experts use the following factors to determine the weight of evidence supporting the effectiveness of a program or practice.

- 1) The type of study used to evaluate the program. Well-executed randomized control trials are generally considered to be the strongest evidence. This design involves randomly assigning participants to receive intervention. Differences between those getting intervention and those serving as the control

group are due to the intervention. The next level involves quasi-experimental designs. Here, results for the intervention group are weighed against those of a group that matched as closely as possible on relevant demographic and other characteristics, but did not receive treatment. However, one cannot rule out that differences in outcomes between the two groups are due to unmatched-for characteristics, rather than the intervention itself.

- 2) The sample size of the study. Larger sizes are generally better, as they are more likely to detect significant effects.
- 3) The degree of participant attrition during the study. High attrition may indicate problems with program implementation and can compromise the integrity of the original randomization or matching process, and thus erode confidence in the results.
- 4) The quality and integrity of the measurement tools and procedures used to measure outcomes.
- 5) The strength of the outcomes observed.
- 6) Whether the positive effects of the intervention are sustained after it has ended compared to the control/comparison group.
- 7) Whether the study has been independently examined by a peer review panel and accepted for publication.
- 8) Replication of positive results across more than one site and/or more than one study.

In selecting evidence-based programs to include in the Early Childhood Blueprint for Change, the United Way strove to find those with the highest-quality evidence of effectiveness in achieving the outcomes outlined in the blueprint, particularly in lower-income, minority, and urban populations.

Fidelity: Fidelity of implementation occurs when implementers of a research-based program or intervention, such as teachers, clinicians or counselors, closely follow or adhere to the protocols and techniques that are defined as part of the intervention. For example, fidelity in a school-based prevention curriculum could mean using the program with the proper grade levels and age groups, and following the developer's recommendations for the number of sessions per week. It could also mean correctly sequencing multiple program components, and conducting assessments and evaluations using the recommended or provided tools.

Gestational (Gestational age): The period of intrauterine development from conception through birth.

Goals: Broad outcomes expected for the community and its children, which, unlike objectives, are not directly measurable.

Indicators: Quantifiable measures of program performance that signify progress (or lack of it) toward a result.

Intervention: Anything meant to change the course of events for someone—such as a treatment, medicine, surgery, information or education program, or counseling.

Knowledge Management: Strategies and processes designed to identify, capture, structure, value, leverage and share an organization's intellectual assets to enhance its performance and competitiveness. It is based on two critical activities: capture and documentation of individual explicit and tacit knowledge; and disseminating that knowledge within the organization.

Literacy Skills Domains: Literacy for children from birth to age five refers to the skills and abilities that are the forerunners of conventional reading and writing.

Objectives: Specific, measurable aims for a strategy that have matching outcomes by which to measure them.

Outcomes: A change in behavior, physiology, attitudes, or knowledge that can be quantified using standardized scales or assessment tools.

Parenting: The United Way uses the word “parenting” in reference to biological parents, grandparents and family members as well as non-biological caretakers of children.

Peer Review Panel: A group of locally and nationally recognized experts, all within the field of early childhood, that offered feedback and counsel on the final draft of the Early Childhood Blueprint.

Postpartum Depression: Severe depression in a woman after she has given birth. It may occur soon after delivery or up to a year later. It most often occurs during the first four weeks after delivery.

Post-Traumatic Stress Disorder (PTSD): An anxiety disorder that develops after experiencing a traumatic event, such as a natural disaster, rape, childhood abuse, car accident or combat.

Public Policy: Any foundation or public-charity activity intended to affect governmental actions. Activities may include building coalitions, community organizing, convening stakeholders, funding demonstration projects, issue advocacy, leadership development, litigation, media and communications, policy research and analysis, public education and voter registration

Secure Attachment: According to attachment theory, a strong emotional bond with a parent or other primary caregiver during childhood. It is a precursor of secure, empathic relationships in adulthood. Failure to form this bond in early childhood will ostensibly give rise to reactive attachment disorder.

Strategy: An approach chosen to bring about a desired future, such as achieving a goal or solving a problem. Also, the art and science of planning and marshalling resources for their most efficient and effective use.

Target Population: The specific group of people or the beneficiaries of a grant project. The individuals in the target population share common characteristics.

Theory of Change: By mapping a process from beginning to end, a theory of change establishes a blueprint for the work ahead and anticipates its likely effects. In addition to revealing what should be evaluated, a theory of change also reveals when and how the evaluation should be conducted.

What We Know and Believe: “What we know” represents what the data tells us about our community and its children. “What we know and believe” represents a compilation of all that we know, assume, and believe about early childhood.

Universal Pre-Kindergarten: A New York State initiative providing four-year-olds access, at no charge, to comprehensive early childhood education experiences that promote their social-emotional, creative expressive/aesthetic, physical, cognitive, linguistic and cultural development.

¹ Data supplied by RCSD Department of Research, Evaluation and Testing indicates that in recent years, 38% of entering kindergarteners had experienced one or more problems in vision, hearing, motor skills, language and cognition.

² Reichman, Nancy E. “Low Birth Weight and School Readiness.” *The Future of Children*, 15 (1), Spring 2005, pp. 91–116. http://www.futureofchildren.org/usr_doc/pg_91_reichman.pdf.

³ Harden, Brenda Jones. “Safety and Stability for Foster Children: A Developmental Perspective.” *The Future of Children*, 14 (1), Winter 2004, pp. 31–47. http://www.futureofchildren.org/usr_doc/3-harden.pdf.

⁴ Currie, Janet. “Health Disparities and Gaps in School Readiness.” *The Future of Children*, 15 (1), Spring 2005, pp. 117–138. http://www.futureofchildren.org/usr_doc/pg_117_currie.pdf.

⁵ Currie, Janet. “Health Disparities and Gaps in School Readiness.” *The Future of Children*, 15 (1), Spring 2005, pp. 117–138. http://www.futureofchildren.org/usr_doc/pg_117_currie.pdf.

⁶ Harden, Brenda Jones. “Safety and Stability for Foster Children: A Developmental Perspective.” *The Future of Children*, 14 (1), Winter 2004, pp. 31–47. http://www.futureofchildren.org/usr_doc/3-harden.pdf.

⁷ Harden, Brenda Jones. “Safety and Stability for Foster Children: A Developmental Perspective” *The Future of Children*, 14 (1), Winter 2004, pp. 31–47. http://www.futureofchildren.org/usr_doc/3-harden.pdf.

Chalk, Rosemary, et al. “The Multiple Dimensions of Child Abuse and Neglect; New Insights into an Old Problem.” *Child Trends Research Brief*. <http://www.childtrends.org/files/childabuserb.pdf>.

Wigg, Janet et al. “Understanding Child Maltreatment and Juvenile Delinquency: From Research to Effective Program, Practice, and Systemic Solutions.” CWLA Press <http://www.cwla.org/programs/juvenilejustice/ucmjhd.htm>.

⁸ Data obtained from Monroe County Department of Human Services indicates that the number of CPS reports in Monroe County steadily increased from 2000 through 2007, from 5819 reports in 2000 to 6948 reports in 2007.

⁹ Lehmann, Christine. “Community Report on Children Entering School in 2006-2007.” Children’s Institute (2007). http://www.childrensstitute.net/download/?file=PACE_Report_07.pdf. Results pertain to survey responses by parents and other caretakers of entering kindergarteners responding to the “Parent Appraisal of Children’s Experience” survey that gave permission for their information to be used in research.

¹⁰ Ofsofsky, Joy. D. “The Impact of Violence on Children.” *The Future of Children*, 9 (3), Winter 1999, pp. 33–49.

¹¹ Children’s Institute, 2007–2007 Pre-K Pace 1.0 results.

¹² Fight Crime: Invest in Kids New York. “Preventing Crime with Pre-kindergarten: A Critical Investment in New York’s Safety” 2006 research brief. <http://www.fightcrime.org/reports/PreKstate06/nyprekbrief.pdf>.

¹³ Fight Crime: Invest in Kids New York. “Preventing Crime with Pre-kindergarten: A Critical Investment in New York’s Safety” research brief. Summarizes information contained in Reynolds, A.J.,

Temple, J.A., Robertson, D.L., and Mann, E.A. (2001). "Long-term effects of an early childhood intervention on educational achievement and juvenile arrest: A 15-year follow-up of low-income children in public schools". *Journal of the American Medical Association*, 285(18), pp. 2339–2346.

¹⁴ Fight Crime: Invest in Kids New York. "Preventing Crime with Pre-kindergarten: A Critical Investment in New York's Safety" research brief. Summarizes information contained in Schweinhart, L.J., Barnes, H.V., & Weikart, D.P. (1993). *Significant benefits: The High/Scope Perry Preschool study through age 27*. Ypsilanti, MI: High/Scope Press.

¹⁵ Children's Institute. "RECAP 2006-07 Tenth Annual Report Facts-at-a-Glance". http://www.childrensinstitute.net/download/?file=RECAPFactsAtAGlance06_07a.pdf

¹⁶ Calculated from 2000 census data obtained from <http://factfinder.census.gov/>. All poverty rates calculated from the relevant population of children under age five for whom poverty status is known. White poverty rates were calculated from those who identified as white only and black poverty rates from those identifying as black only (i.e. persons identifying themselves as multiracial were not included). The census treats Hispanic ethnicity as distinct from race so that persons that identify as Hispanic may also be represented in the white and black racial categories.

¹⁷ Data from NYSDOH and MCHD obtained through Metro Council for Teen Potential. Number of classrooms calculated using estimated average class size of 22 kindergarteners.

¹⁸ Currie, Janet., "Health Disparities and Gaps in School Readiness." *The Future of Children*, 15 (1), Spring 2005, pp. 117–138. http://www.futureofchildren.org/usr_doc/pg_117_currie.pdf.

New York State Department of Health. "Eliminating Childhood Lead Poisoning in New York State by 2010." June 2004, <http://www.health.state.ny.us/environmental/lead/exposure/childhood/finalplantoc.htm>. The latter report notes that research indicates that children may experience harmful effects at blood lead levels below 10 micrg/dL, the current "level of concern" defined by the Centers for Disease Control and Prevention.

¹⁹ Data provided by MCHD. The number screened is an unduplicated count of all children under age six tested in Monroe County during 2007, excluding those previously identified as lead poisoned and who were tested as part of ongoing case management. The children included in the number identified with elevated blood lead tests had at least one venous or finger-stick test that showed a lead level at 10 mcrg/dL or higher (again, excluding those in ongoing case management for lead poisoning).